

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09780

9771

CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Garrett</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural Grantsville</u>		<u>40 yrs.</u>		OR TOWN <u>Rural Grantsville, Md.</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100				1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>JAMES</u> (Middle) <u>WESLEY</u> (Last) <u>BITTINGER</u>				Oct. 20 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>July 29, 1900</u>	<u>55</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Miner</u>		<u>Coal Mines</u>		<u>George Creek Area, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Joseph Bittinger</u>				<u>Eliza Broadwater</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>212-18-1465</u>		<u>Mrs Della Bittinger, Grantsville,</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
152X IMMEDIATE CAUSE (A) <u>Carcinoma of the small intestine</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>1953</u>		<u>indolgent growth involving ascum</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/15</u> , 19 <u>55</u> , to <u>10/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/19</u> , 19 <u>55</u> , and that death occurred at <u>6:00 P.</u> M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>A. Paige Strong</u>				<u>Salisbury, Pa.</u>			
DATE SIGNED				DATE SIGNED			
<u>10/22/55</u>				<u>10/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/23/55</u>		<u>Bittinger</u>		<u>Bittinger, Garrett Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>10-22/55</u>		<u>Ethel Broadwater</u>		<u>Donald J. Newman</u>		<u>Grantsville, Md.</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH

1. Name of deceased: _____
 2. Sex: _____
 3. Age: _____
 4. Date of birth: _____
 5. Place of birth: _____
 6. Date of death: _____
 7. Place of death: _____
 8. Cause of death: _____
 9. Manner of death: _____
 10. Signature of physician: _____
 11. Signature of registrar: _____
 12. Date of registration: _____

BUREAU V. 2.

NOV 28 1955

RECEIVED

Handwritten signature

MASSACHUSETTS DEPARTMENT OF HEALTH

MASSACHUSETTS DEPARTMENT OF HEALTH
 BUREAU OF VITAL RECORDS
 100 STATE STREET, 10TH FLOOR
 BOSTON, MASSACHUSETTS 02109

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9772

CERTIFICATE OF DEATH

09781

Reg. Dist. No. 162

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural Grantsville</u>		<u>life</u>		TOWN <u>Rural Grantsville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>DEBRA</u> (Middle) <u>LYNNE</u> (Last) <u>BOWSER</u>				<u>Oct. 26,</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>single</u>	<u>July 24, 1955</u>	<u>---</u> yrs.	<u>3</u> Months	<u>2</u> Days	<u>---</u> Hours <u>---</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>infant</u>		<u>Meyersdale Community Hosp. U.S.A.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Hubert Luther Bowser</u>				<u>Dortha Elleen Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>(If Yes, give war or dates of service)</u>		<u>none</u>		<u>Mrs. Hubert Bowser, Grantsville, Md. R.D.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>571.0</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>acute gastro enteritis</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>OCT 24</u> , 19 <u>55</u> , to <u>OCT 27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>OCT 26</u> , 19 <u>55</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Leonard L. Lock</u> M.D.				ADDRESS (Street, city, town, state) <u>Meyersdale, Pa.</u>		DATE SIGNED <u>10/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/28/55</u>		<u>Zion Lutheran</u>		<u>Accident, Garrett Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Ethel Broadwater</u>		<u>William</u>		<u>Grantsville, Md.</u>	
DATE <u>10/27/55</u>							

CERTIFICATE OF DEATH

DATE

FILE NO.

PLACE OF DEATH

DECEASED

AGE

SEX

CAUSE

DATE

TIME

PLACE

CITY

COUNTY

STATE

COUNTRY

DECEASED

DATE

TIME

PLACE

CITY

COUNTY

STATE

COUNTRY

DECEASED

DATE

TIME

PLACE

CITY

COUNTY

STATE

COUNTRY

DECEASED

DATE

TIME

PLACE

CITY

BUREAU V. 2

DEC 21 1955

RECEIVED

RECEIVED

9773

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Garrett.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Friendsville</u>				TOWN <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <u>Nettie</u>		(Middle) <u>A</u>		(Last) <u>Coddington.</u>		DATE: <u>Oct 30, 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>Oct 30, 1872</u>	9. AGE last birthday: <u>83</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Garrett Co, Maryland.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Addison Frazee</u>				14. MOTHER'S MAIDEN NAME: <u>Caroline Harden.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Earl Coddington Friendsville, Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.0 Immediate cause (a) <u>Coronary THROMBOSIS</u>						5 min.	
Antecedent cause(s) (b) <u>Arteriosclerotic Heart Disease</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY?							
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	
SUICIDE <u>No</u>		HOMICIDE <u>No</u>		INJURY			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Aug 6, 1955</u> , to <u>Oct 30, 1955</u> , that I last saw the deceased alive on <u>Oct 29, 1955</u> , and that death occurred at <u>9:50 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Weldon Jaffer, M.D.</u>				(DEGREE OR TITLE) <u>M.D.</u>		ADDRESS <u>Friendsville, Md</u>	
DATE SIGNED <u>Oct 31, 1955</u>							
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>11-2-55</u>		NAME OF CEMETERY OR CREMATORY <u>Addison Cemetery.</u>		LOCATION (City, town, or county) (State) <u>Addison, Pa</u>	
DATE REC'D BY LOCAL REG. <u>Oct 31 1955</u>		REGISTRAR'S SIGNATURE <u>Mrs Ruth Frantz Deputy</u>		24. FUNERAL DIRECTOR <u>H. B. Pischelberger</u>		ADDRESS <u>ADDISON, PA.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

NOV 2 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

09783

9774

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH - COUNTY <u>Barnett</u> STATE <u>MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Barnett</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Friendsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Friendsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>STANLEY</u> (Middle) <u>JENNINGS</u> (Last) <u>FRIEND</u>		4. DATE OF DEATH (Month) <u>Oct</u> (Day) <u>30</u> (Year) <u>1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Feb 23, 1902</u>
9. AGE last birthday <u>53</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Friendsville, Md</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired, state) <u>mines. retired</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>coal mine</u>	
12. FATHER'S NAME <u>Josephus Friend</u>		13. MOTHER'S MAIDEN NAME <u>Eliza Ellen Stark</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>with</u>		15. SOCIAL SECURITY NO. <u>217-07-8653</u>	
16. INFORMANT AND ADDRESS <u>Beard McClellough - Friendsville, Md</u>		17. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
434.3 Immediate cause (a) <u>Heart disease - probably failure</u>		4-5 yrs.
Antecedent cause(s) (b) <u>Heart attack July 54</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>none</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19b. MAJOR FINDINGS OF OPERATION		
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		
PLACE (Home, farm, factory, street, or office bldg., etc.) <u>at work</u>		(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE <u>Thomas D. Lushy</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>Caliland, Md.</u>		DATE SIGNED <u>10/30/55</u>
23. BURIAL, CREMATION OR OTHER DISPOSITION (Specify) <u>Burial</u>	DATE TIME OF <u>Nov. 2, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>	LOCATION (City, town, or county) <u>Listonburg,</u>	(State) <u>Ta.</u>		
DATE REC'D BY LOCAL REG. <u>Nov. 1, 1955</u>	REGISTRAR'S SIGNATURE <u>Mrs Ruth Frantz</u>	24. FUNERAL DIRECTOR <u>Jack A. Friend</u>		ADDRESS <u>Friendsville, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 3 1955

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A5C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10864

9775

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		STATE <u>MARYLAND</u>		COUNTY <u>GARRETT</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u>		LENGTH OF STAY (in this place) <u>4 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ACCIDENT</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u></u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>CLEMENS</u> <u>C.</u> <u>GOEHRINGER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>OCTOBER 27</u> <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SEP.</u>	8. DATE OF BIRTH <u>8/30/1898</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAIL CARRIER & BUS DRIVER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>ACCIDENT, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>WILLIAM GOEHRINGER</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Lockner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>AUBRA GOEHRINGER ACCIDENT, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
157X IMMEDIATE CAUSE (A) <u>TRAI NUTITION</u>						<u>8 wks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CARCINOMA HEAD OF PANCREAS</u>						<u>7 mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u></u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>April 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma Head of Pancreas</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 30, 1955</u> to <u>Oct 27, 1955</u> , that I last saw the deceased alive on <u>Oct 27, 1955</u> and that death occurred at <u>10:58 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James H. Decker, Jr.</u>				ADDRESS (Street, city, town, state) <u>M.D. 58 2nd St. Oakland, Md.</u>		DATE SIGNED <u>10-27-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/31/55</u>		NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran</u>		LOCATION (City, town, or county) (State) <u>Accident, Garrett Co., Md.</u>	
24. REC'D BY REGISTRAR <u>10/29/55</u>		REGISTRAR'S SIGNATURE <u>Julia A. Rowan</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Phorald F. Newman</u>		ADDRESS <u>Grantsville, Md.</u>	

CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Manner of death: _____
10. Signature of physician: _____
11. Signature of registrar: _____
12. Date of registration: _____

BUREAU V. S.

RECEIVED
JUN 10 1955

NOTED ABOVE

9776

CERTIFICATE OF DEATH

Reg. Dist. No.

166

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY GARRETT	MARYLAND	STATE MD	COUNTY GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN CRELLIN	1 WEEK	TOWN CRELLIN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
(First) STELLA	(Middle) MAE	(Last) HADDIX	(Month) OCT.	(Day) 26	(Year) 1953
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH JULY-10-1895	9. AGE last birthday 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SWALLOW FALLS MD	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME HENRY MCSABE			14. MOTHER'S MAIDEN NAME MAHALA KEISNER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT & ADDRESS SAMUEL HADDIX CRELLIN MD.		

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) CEREBRAL VASCULAR ACCIDENT				2 days	
ANTECEDENT CAUSE(S) DUE TO (B) GENERALIZED ARTERIOSCLEROSIS				?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) BLINDNESS				5yr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from **DEATH** **1945**, to **OCT.** **1953**, that I last saw the deceased alive on **OCT 25**, 19**53**, and that death occurred at **1 P.** M, from the causes and on the date stated above.

SIGNATURE **[Signature]** M.D. **Belknap** ADDRESS (Street, city, town, state) **Belknap MD** DATE SIGNED **10/27/53**

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	DATE THEREOF OCT 28 1953	NAME OF CEMETERY OR CREMATORY ASHBY CEMETERY	LOCATION (City, town, or county) NEAR CRELLIN	(State) MD
24. REC'D BY REGISTRAR [Signature]	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS BELKNAP OAKLAND MD		

VS A15C 1-55 10M

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

INSTRUCTIONS

[illegible]

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9777

CERTIFICATE OF DEATH

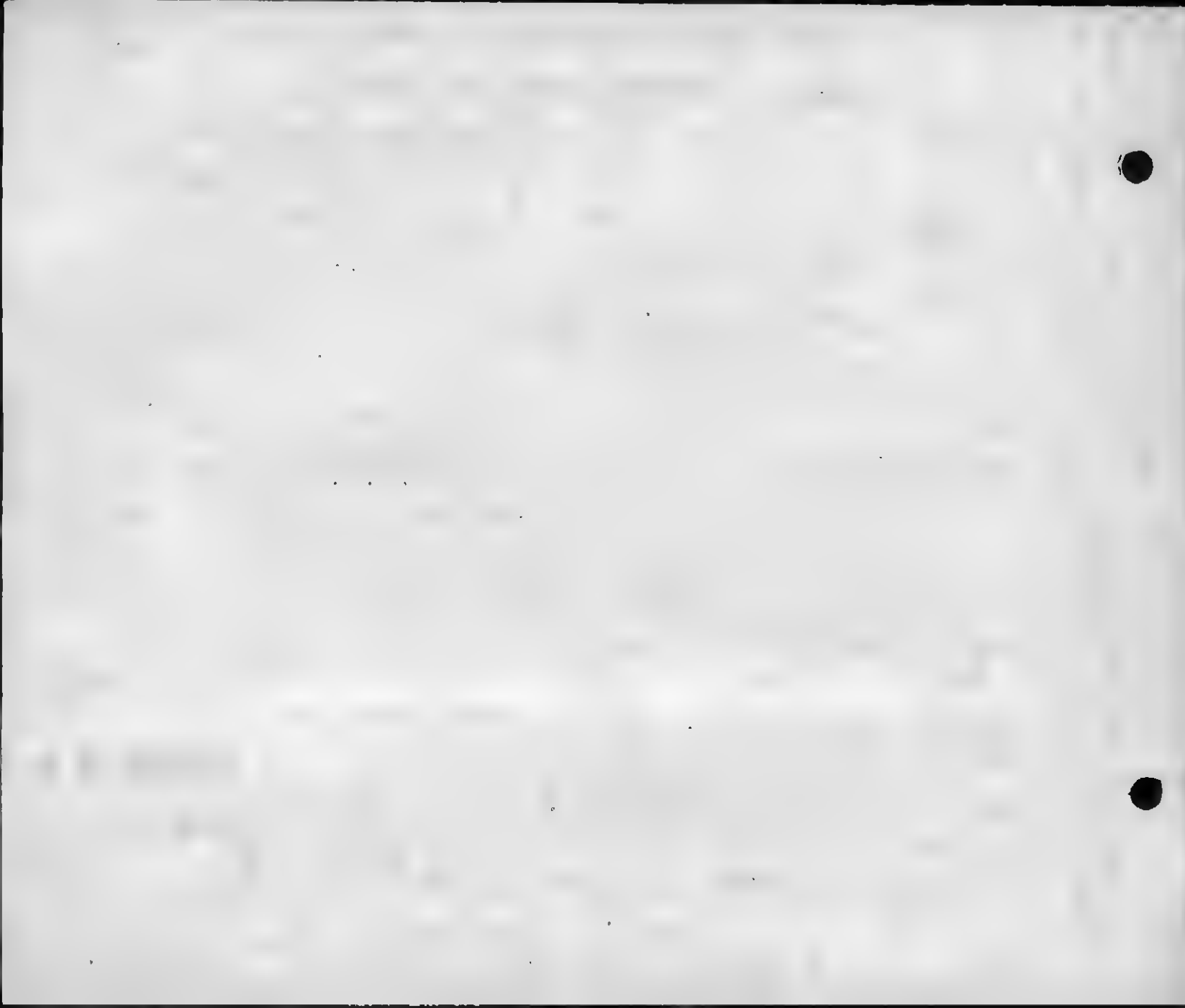
09785
166

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY GARRETT		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN OAKLAND		7 Days		TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS GARRETT COUNTY MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) ROUTE 3, BEDFORD ROAD			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
FRANK S. HOLAHAN				OCTOBER 5 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
M	W	DIVORCED	December 21 1880	74 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Lawyer		Practicing Law		1 Troy NEW YORK		U. S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
HOLAHAN, HUGH				GAY, JOSEPHINE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		MRS. W. S. RELLING Cumberland Md			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
c31X IMMEDIATE CAUSE (A)				Central Hemorrhage			
ANTECEDENT CAUSE(S) DUE TO				Arterio Sclerosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		12 Days 7 years	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 30 Sept, 1955, to 5 Oct, 1955, that I last saw the deceased alive on 4 Oct, 1955, and that death occurred at 2:45 AM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
L. S. Phance				Oakland Md		5 Oct 55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct 7 1955		St. Mary's Cemetery		Cumberland, Md	
24. RECEIVED BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
10/6/55		John G Rowan		H. Knight		Cumberland, Md.	

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09786

9778

CERTIFICATE OF DEATH

Reg. Dist. No. 166

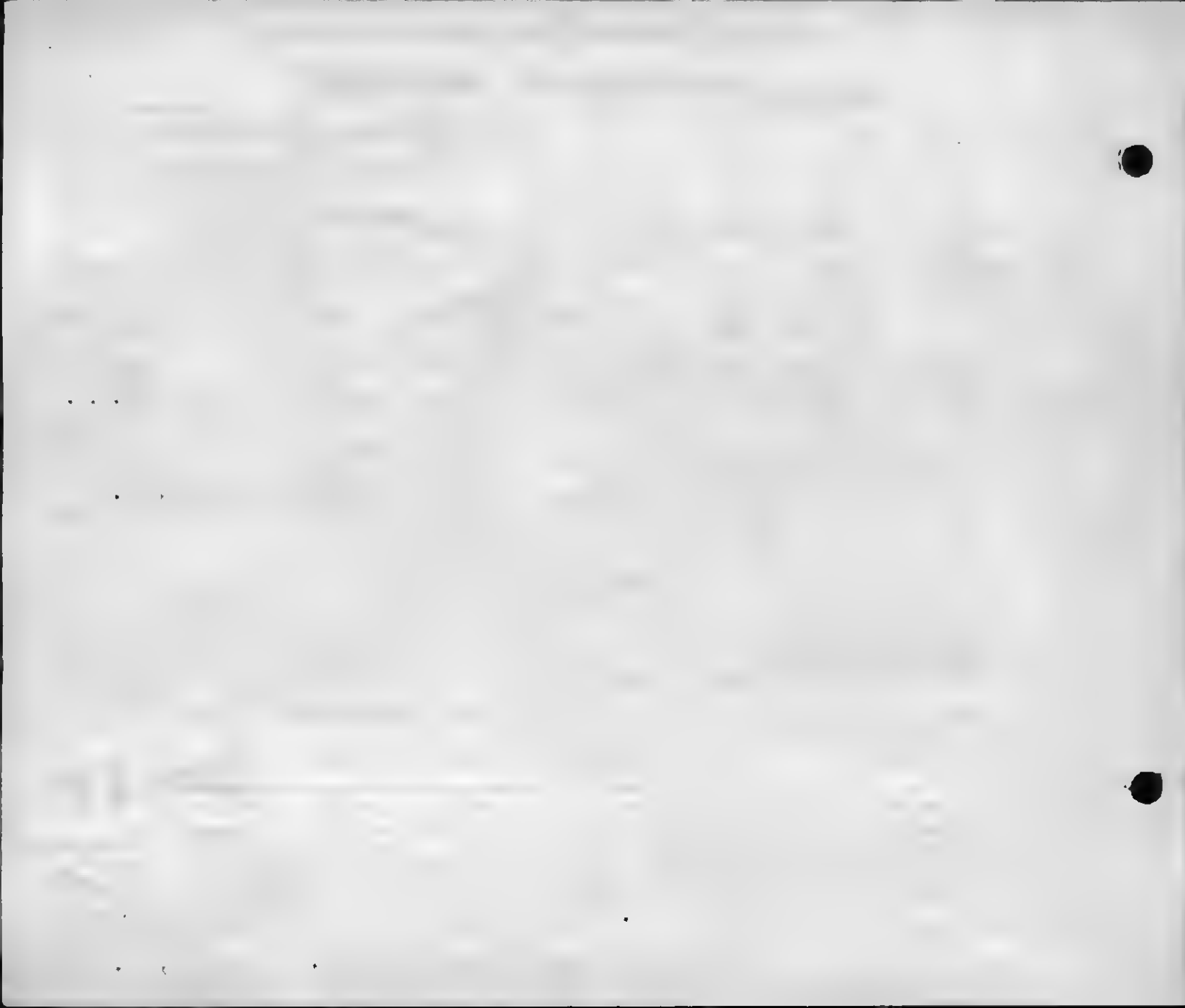
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garret</u> <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN <u>Oakland</u>		TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Evans Nursing Home</u>		STREET ADDRESS <u>219 Maryland Ave</u>		STREET ADDRESS (If rural give location)		V	
3. NAME OF (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Regina E Hopcraft</u>				<u>Oct. 10, 1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>3/2/1897</u>	
9. AGE last birthday <u>58</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Michial Grady</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Jesse Hopcraft Cumberland, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Malignant Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 8, 1955</u> , to <u>Oct 10, 1955</u> , that I last saw the deceased alive on <u>Oct. 10, 1955</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>E. J. Stein, Inc.</u>				ADDRESS (Street, city, town, state) <u>25 Alder St. Oakland, Md.</u> DATE SIGNED <u>10/11/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>10/11/55</u>		DATE THEREOF <u>10/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Patrick Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
24. REC'D BY REGISTRAR <u>10/11/55</u>		REGISTRAR'S SIGNATURE <u>J. H. K. K. K.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Louis Stein, Inc. Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09787

9779

CERTIFICATE OF DEATH

Reg. Dist. No. 167

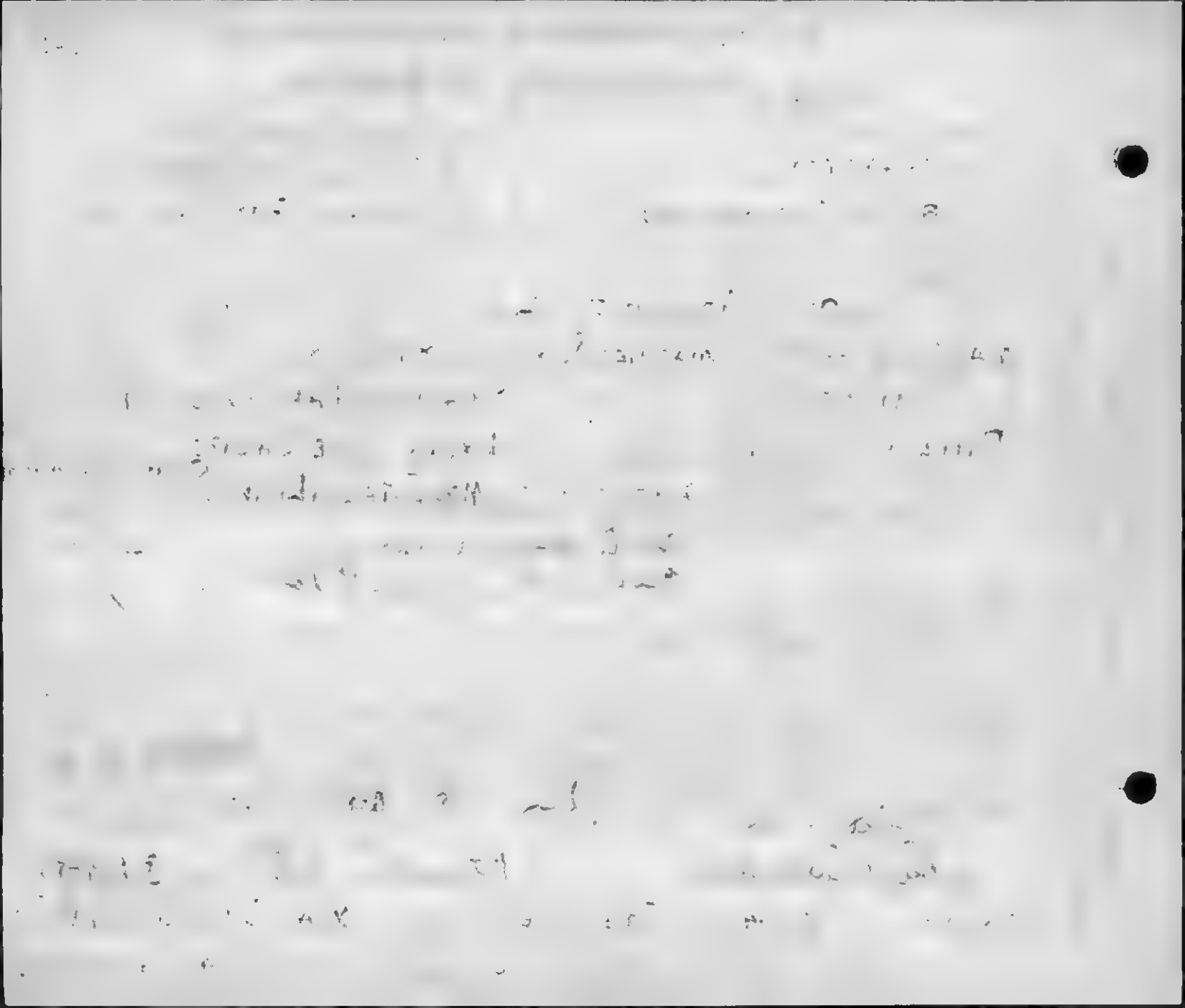
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>GARRETT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>RURAL GORMAN MD</u>				TOWN <u>RURAL GORMAN MD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last)							
<u>EMORY ADOLPHOS LEWIS</u>				<u>OCT - 1 1953</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>JUNE - 9 - 1895</u>	<u>80</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>MINER</u>						<u>SWALLOW FALLS MD.</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
<u>U.S.</u>				<u>PHILIP LEWIS</u>			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			
<u>LYDIA SPEICHER</u>				<u>NO</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS			
<u>612-24-1741</u>				<u>MRS ESTELLA LEWIS</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X IMMEDIATE CAUSE (A)				<u>Acute Myocardial Infarction</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Coronary Artery Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>D</u>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>Oct 1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 2</u> , 19 <u>55</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, City, town, state)		DATE SIGNED	
<u>Keith Calandella</u>				<u>MD</u>		<u>Oct 3 - 55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>BURIAL</u>		<u>OCT-4-1953</u>		<u>FRIEND CEMETERY</u>		<u>NEAR SWALLOW FALLS MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>10/3/53</u>		<u>Elmer C. Sager</u>		<u>Emory Bolden</u>		<u>OAKLAND MD</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



1

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

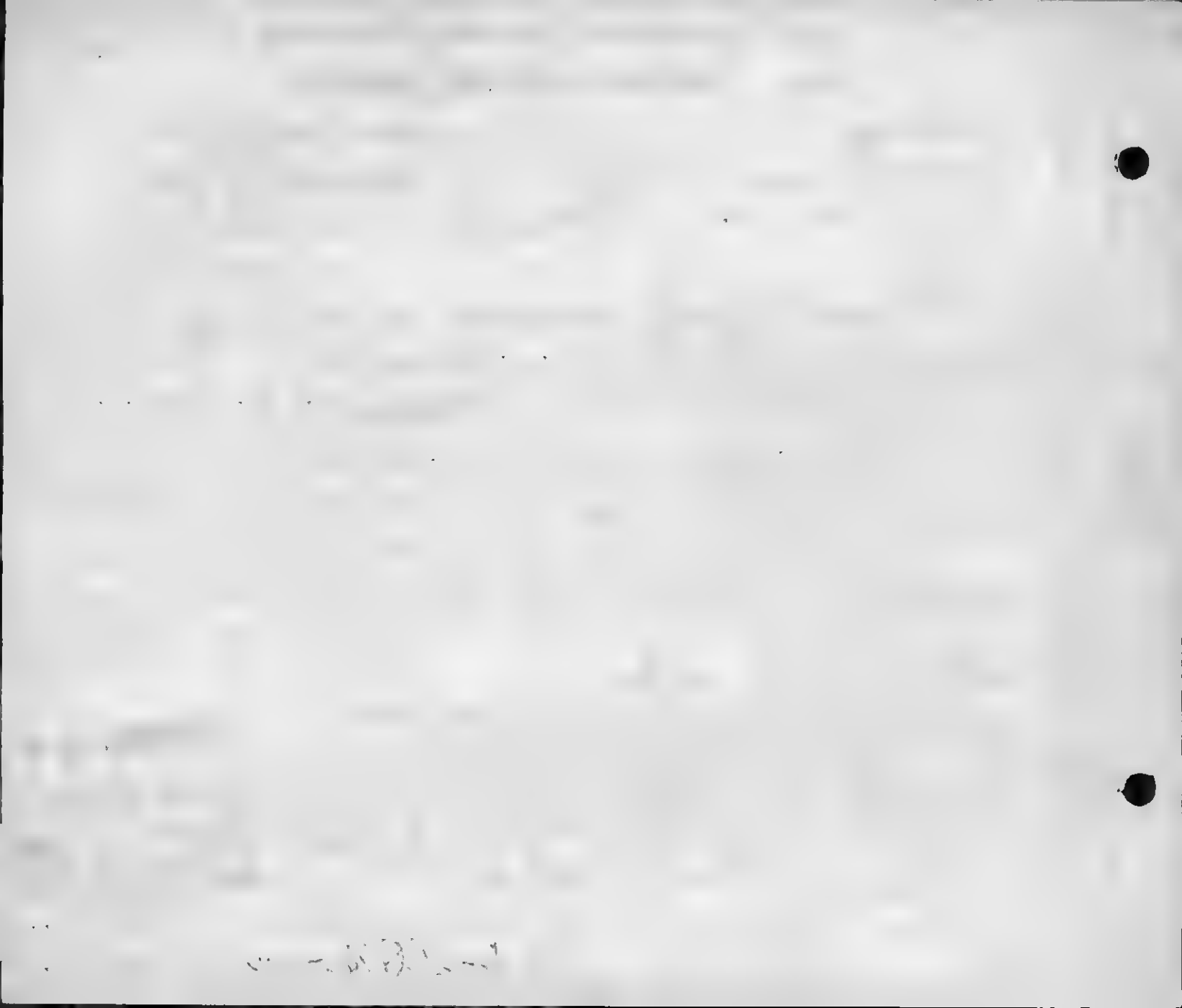
9780

CERTIFICATE OF DEATH

09788

Reg. Dist. No. 162

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Garrett</u>	MARYLAND	STATE <u>MARYLAND</u> COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Grantsville, Md.</u>	<u>2 weeks</u>	TOWN <u>EMMITTSBURG, MD.</u>	<u>1-X-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last) <u>CATHERINE MARGARETHA MILLER</u>		(Month) (Day) (Year) <u>Oct-23 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Dec. 5, 1878</u>
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<u>76</u> yrs.	<u>Housewife</u>	<u>Cove, Garrett Co., Md.</u>	<u>U.S.A.</u>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
<u>Charles C. Hamft</u>	<u>Anna M. CESTER</u>	<u>none</u>	
16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	18. MEDICAL CERTIFICATION	
<u>none</u>	<u>Christian Miller, Grantsville, Md.</u>	I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
<u>None</u>		<u>Bilateral broncho pneumonia</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>October 9, 1955</u> , to <u>Oct 23, 1955</u> , that I last saw the deceased alive on <u>Oct 22, 1955</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.		23. BURIAL, CREMATION, REMOVAL (SPECIFY)	
SIGNATURE <u>G. Paige Strong</u> M.D.		DATE THEREOF <u>10/26/55</u>	
ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		LOCATION (City, town, or county) (State) <u>Grantsville, Garrett Co., Md.</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE <u>Ethel Broadwater</u>		ADDRESS <u>Grantsville, Md.</u>	
DATE <u>10-25-55</u>			



INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9781

CERTIFICATE OF DEATH

09789

Reg. Dist. No. 163

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Garrett</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bloomington</u>		<u>28 years</u>		TOWN <u>Bloomington</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Mollie</u> (Middle) <u>MARY</u> (Last) <u>Moorehead</u>				<u>Oct 28</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Dec 10, 1869</u>	<u>86</u> yrs	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic</u>		<u>Own home</u>		<u>Bergh W. Va</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Conley</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Don</u> <u>Louise Moorehead, Bloomington</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.						INTERVAL BETWEEN ONSET AND DEATH	
177.1 IMMEDIATE CAUSE (A)						<u>1 yr</u>	
ANTECEDENT CAUSE(S) DUE TO (B)						<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)						<u>6 mo.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/1</u>, 19<u>55</u>, to <u>10/28</u>, 19<u>55</u>, that I last saw the deceased alive on <u>10/28</u>, 19<u>55</u>, and that death occurred at <u>2 A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>P. E. Barry</u>				DATE SIGNED <u>10/29/55</u>			
				ADDRESS (Street, city, town, state) <u>W. Va.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-30-55</u>		<u>Philas Cemetery</u>		<u>Westport, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Dorothy Pattison</u>		<u>E. J. Bral</u>		<u>Westport, Md</u>	
DATE <u>10-30-55</u>							



1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9782

CERTIFICATE OF DEATH

09730

Reg. Dist. No. 161

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY GARRETT		MARYLAND		STATE MD		COUNTY GARRETT	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN FRIENDSVILLE		20 YRS.		TOWN FRIENDSVILLE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
RUSSELL BERNARD ROSE				Oct 5 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	WIDOWED	MARCH-15-1877	78 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
RAILROADER					BRADDOCK PA.		U.S.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
RUSSELL ROSE				DEALERS LISTON.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS			
				EDWARD ROSE 895 B. ST. MEADVILLE PA.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				10. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A)				Coronary Thrombosis			
ANTECEDENT CAUSE(S) DUE TO				Arteriosclerotic heart disease			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
none							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from May 1952, to Oct 3, 1955, that I last saw the deceased alive on Oct 3, 1955, and that death occurred at 7:30 A.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Milton Zepf				Oct 5, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. REC'D BY REGISTRAR			
BURIAL				Ruth Frantz			
DATE OF THEROF				NAME OF CEMETERY OR CREMATORY			
Oct-8-1955				BRADDOCK CEMETERY			
LOCATION (City, town, or county)				(State)			
NORTH BRADDOCK				PA.			
25. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS			
Emory Bolden				OAKLAND MD			

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9783

CERTIFICATE OF DEATH

09781
166

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		STATE <u>MD</u>		COUNTY <u>GARRETT</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>OAKLAND</u>		<u>3 MONTHS</u>		TOWN <u>OAKLAND</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EVANS NURSING HOME</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARY</u> (Middle) <u>E</u> (Last) <u>SEBOLD</u>				(Month) <u>OCT.</u> (Day) <u>23</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>SINGLE</u>	<u>NOV. - 21 - 1875</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>MD</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>ANDREW SEBOLD.</u>				<u>KATHRYN GROWER.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>JOSEPH SEBOLD M^{rs} HENRY MID.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>Cardiac Failure - Acute</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>				<u>2 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Sclerotic Heart Disease</u>				<u>years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/> A. <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>7-11</u> , 19 <u>55</u> , to <u>10-23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9-7</u> , 19 <u>55</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>10-24-55</u>			
ADDRESS (Street, city, town, state) <u>58 and 32 OAKLAND MD</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>OCT-26 1955</u>		<u>OAKLAND CEMETERY</u>		<u>OAKLAND MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>10/26/55</u>		<u>Julia A Rowan</u>		<u>Emory Bolden</u>		<u>OAKLAND MD.</u>	

INSTRUCTIONS

1
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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

DECEASED
GARDNER
GARDNER

DECEASED
GARDNER
GARDNER
LIVING HOME

DATE OF DEATH
MAY 19 1913

PLACE OF DEATH
SINGLETON - 11-12-13

AGE
MAY 19 1913

CAUSE OF DEATH
KATHERINE GARDNER

DECEASED
KATHERINE GARDNER

BUREAU V. S.

NOV 18 1913

RECEIVED

OUT-POST GARDNER
GARDNER
GARDNER

9734

CERTIFICATE OF DEATH

09792

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>GARRETT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>OAKLAND</u>		3 days		TOWN <u>JENNINGS</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JACOB</u> (Middle) (Last) <u>STARK</u>				(Month) (Day) (Year)			
				<u>OCTOBER 24, 1955.</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
M	W	WIDOWED, DIVORCED, ✓	<u>Sept 24, 1884</u>	71 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Woodman</u>		<u>Timber</u>				<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Stark</u>				<u>Martha Hetrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>213-18-2562</u>		<u>Sheriff Paul Fisher, Oakland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
32001 (C) <u>Acute Alcoholism</u>						<u>3 day</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M. at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Oct 21, 1955</u> , to <u>Oct 24, 1955</u> , that I last saw the deceased alive on <u>Oct 24, 1955</u> , and that death occurred at <u>8:00 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dr. Chamyathner</u> M.D.				ADDRESS (Street, city, town, state) <u>Oakland, Md.</u>		DATE SIGNED <u>8/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/27/55</u>		<u>Bethesda</u>		<u>Bittinger, Garrett Co., Md.</u>	
24. RECD BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>10/26/55</u>		<u>Julia A Rowen</u>		<u>Dorothy H. Rowen</u>		<u>Bantsville, Md.</u>	

INSTRUCTIONS

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2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Duration of illness

8. Signature of physician

9. Signature of registrar

10. Signature of informant

11. Signature of witness

12. Signature of witness

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INSTRUCTIONS

BUREAU V. S.

NOV 11 1951

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